

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-036983

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2547

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED SEP 20 1962

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Saint Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Normandy (21)		c. CITY OR TOWN Overland (14)	
Length of stay in lb 17 Days		Inside Limits Yes No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Home Charles the 1st Nursing		d. STREET ADDRESS (If outside, give location) 12255 Design Lane	
3. NAME OF DECEASED (Type or print) First Middle Last GUY ESTES CODAY		4. DATE OF DEATH Month Day Year Sept. 1, 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/16/95
9. AGE (last birthday) 67		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rate Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (City and state or country) Mansfield, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown Johnson	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Creve Cœur (41) Mo Roderick Coday #19 Gandy Dr.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from FEBRUARY 1961 to Sept 1, 1962 and last saw her alive on Sept Aug 31, 1961 Death occurred at 9:05p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul M Larson, M.D.		22b. ADDRESS 6214 Washington Ave.	
22c. DATE SIGNED Sept 2, 62		22d. DATE RECD. BY LOCAL REG.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/5/62	23c. NAME OF CEMETERY OR CREMATORY G. A. R. Cemetery	23d. LOCATION (City, town, or county) (State) Miami, Oklahoma
24. FUNERAL DIRECTOR Fendler Und. Co. 7420 Michigan Ave.		25. REGISTRAR'S SIGNATURE John B. Murphy M.D.	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

Dr. Paul Larson

3654 So. Grand Mo. 4-5500 Office

6814 Washington No 3. 3555 Home

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

W. G. Peterson

Licensed Embalmer No.

3767

P. O. Address

7420 Michigan

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.